Commonwealth of Virginia
Department of Human Resource Management

State Health Benefits Program

Eligibility, Elections And Enrollment Information For Employees

Overview

The following is a general description of the Commonwealth of Virginia's State Health Benefits Program eligibility and enrollment information for employees. It is not intended to replace member handbooks and other plan documents. Please read this information thoroughly before making any election and keep pages 1-4 for quick reference.

Employees are responsible for reviewing plan documents and becoming knowledgeable about their benefits. For more detailed information or clarification, visit the DHRM Web Site at **www.dhrm.virginia.gov** or contact your Benefits Administrator.

Participation in the State Health Benefits Program is subject to current program provisions, state and federal laws and regulations, and plan availability. The Commonwealth reserves the right to change your enrollment to ensure compliance.

Who Is Eligible?

All full-time or part-time, salaried, classified employees or regular, full-time or part-time, salaried faculty members are eligible for the health benefits program.

What Election Choices are Available?

Flexible Reimbursement Accounts allow you to set aside part of your salary each pay period before taxes. The minimum deposit is $10 per pay period and the maximum deposit is $5,000 annually.

- A *Medical Reimbursement Account* provides reimbursement for certain expenses incurred by you and your eligible family members. Included are eligible medical, dental and vision care expenses not covered by your health plan.

- A *Dependent Care Account* provides reimbursement for eligible expenses for the care of your child (age 12 or under), disabled spouse, elderly parent or other dependent incapable of self-care.

Important Things To Know About Flexible Reimbursement Accounts:

- Enrollment in a flexible reimbursement account authorizes the reduction of the gross salary by the elected reimbursement account contributions as indicated for the duration of the coverage period.

- A flexible reimbursement account election may not be revoked, changed, or modified during the plan year unless the revocation and new election are on account of and consistent with a qualifying mid-year event.

- Any amount remaining in a flexible reimbursement account not used for qualifying expenses incurred during your coverage period is forfeited.

- A flexible reimbursement account must only be used to pay for IRS-qualified expenses and only for IRS-eligible dependents.

- Enrollees must exhaust all other sources of reimbursement (including those provided under an employer's plans) before seeking reimbursement from a flexible reimbursement account. They may not seek reimbursement through any other source.

- Enrollees must collect and maintain sufficient documentation to validate reimbursement from a flexible reimbursement account.

Health Care Coverage provides you medical, dental, pharmacy, and behavioral health services. Certain family members may also be covered:

- Legally married spouse*
- Dependent child under age 23**
- Disabled dependent child age 23 or older***

* A court order to provide coverage for a divorced spouse does not make the ex-spouse eligible for coverage under your health care plan.

** A dependent child must be unmarried, live at home or away at school and receive over one-half of his or her support from the employee. A dependent child is defined as: your biological child, your legally adopted child, your stepchild living with you in a parent-child relationship, a child placed in your home under a pre-adoptive agreement approved by the State Health Benefits Program, or a child placed in your home under a permanent custody court order. In the case of natural or adopted children, living at home may mean living with the other parent if the employee is divorced. *With supporting documentation, the program may determine when other children may qualify as dependent children.*

*** A disabled dependent child may continue coverage if the qualifying disability was diagnosed prior to the loss of eligibility due to age, and your request to continue coverage is approved by the health care plan. A disabled dependent child who later recovers is no longer eligible and must be removed from coverage.

Important Things To Know About Health Care Coverage:

- Employees who enroll or fail to remove a family member who is not eligible for coverage may face disciplinary action and removal from the State Health Benefits Program for up to three years.
- In the event of an employee's death, enrolled family members may continue coverage under the employee's agency for an additional month. More information about eligibility and enrollment for a Survivor is available on the DHRM Web Site or from your Benefits Administrator.
- Continued coverage is available for you and covered family members who lose eligibility under the State Health Benefits Program. More information about Extended Coverage (COBRA) is available on the DHRM Web Site or from your Benefits Administrator.
- A Certificate of Coverage as defined by the Health Insurance Portability and Accountability Act (HIPAA) is available from your Benefits Administrator if you become covered under another group health plan that requires evidence of your prior health care coverage.

Important Things To Know About Health Plan Premiums:

- Plans and premiums are subject to change.
- Employee premium amounts apply to most full-time employees. However, full-time employees on certain leaves of absence pay the total premium.
- All part-time employees pay the total premium.
- Payroll-deducted premiums are withheld on a pre-tax basis.
- Employees are obligated to pay for any month of health care coverage already begun.
- Failure to pay the premium owed results in cancellation of coverage and forfeits any partial payment.

Health Care Plans and Benefits At-A-Glance for 2006

	COVA Care Health Plan	High Deductible Health Plan	Kaiser Permanente HMO
Deductible	$200 per person $400 per family	$1,200 per person $2,400 per family	None None
Out-Of-Pocket	$1,500 per person $3,000 per family	$5,000 per person $10,000 per family	None None
Office Visit	$25 PCP $35 Specialist	20% coinsurance after deductible	$10 PCP $10 Specialist
Retail Pharmacy	Up to 34-day supply $15 Tier 1 $20 Tier 2 $35 Tier 3	20% coinsurance after deductible	Up to 60-day supply $10 Kaiser pharmacy $20 Community pharmacy
Home Delivery Pharmacy	Up to 90-day supply $30 Tier 1 $40 Tier 2 $70 Tier 3	20% coinsurance after deductible	Up to 90-day supply $8 Mail Service
Hospital	$300 per stay	20% coinsurance after deductible	$100 per admission
Emergency Room	$100 per visit (waived if admitted)	20% coinsurance after deductible	$50 per visit (waived if admitted)
Outpatient diagnostic labs and x-rays	10% coinsurance after deductible	20% coinsurance after deductible	$0 after office visit copay

Health Care Plans and Premiums Effective July 1, 2006 – June 30, 2007

	You Only	You + One	You + Two or More
High Deductible Health Plan			
Employee pays	$0	$0	$0
Total premium	$335	$620	$906
COVA Care Health Plan + Basic Dental			
Employee pays	$40	$99	$140
Total premium	$418	$774	$1,131
COVA Care Health Plan + Out-Of-Network			
Employee pays	$50	$112	$158
Total premium	$428	$787	$1,149
COVA Care Health Plan + Expanded Dental			
Employee pays	$52	$123	$176
Total premium	$430	$798	$1,167
COVA Care Health Plan + Out-Of-Network + Expanded Dental			
Employee pays	$62	$136	$194
Total premium	$440	$811	$1,185
COVA Care Health Plan + Expanded Dental + Vision & Hearing			
Employee pays	$61	$139	$197
Total premium	$439	$814	$1,188
COVA Care Health Plan + Out-Of-Network + Expanded Dental + Vision & Hearing			
Employee pays	$71	$152	$214
Total premium	$449	$827	$1,205
Kaiser Permanente HMO – available only in Northern Virginia			
Employee pays	$39	$96	$135
Total premium	$404	$747	$1,091

When Can I Request Enrollment or Election Changes?

When Newly Eligible

For health care coverage and flexible reimbursement accounts, request enrollment within 31 days of the date of hire or of becoming eligible.

During Open Enrollment

The Open Enrollment period occurs each spring and is your annual opportunity to enroll or make election changes to flexible reimbursement accounts and health care coverage. The benefits and premiums associated with open enrollment elections are effective the following July 1.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your agency's Benefits Administrator.

Qualifying Mid-Year Events

Certain qualifying mid-year events permit election changes outside the Open Enrollment period. Examples of qualifying mid-year events include changes in your employment, changes in your marital status, changes in the number of your eligible family members, and changes affecting the employment of a covered family member. Your change request must be received within 31 days of the event and be on account of and consistent with the event. You may be asked to provide supporting documentation. A complete list of qualifying mid-year events may be found on the DHRM Web site and on the attached enrollment form.

When Are Enrollment or Election Changes Effective?

Coverage always begins on the first of a month and ends at the end of a month. Most requests received within 31 days and by the end of the month are effective the first of the next month. *There are two exceptions:* coverage for a newborn or adopted child, and when a family member loses eligibility as a dependent.

How Do I Request Enrollment or Election Changes?

- **Online:** Visit the DHRM Web site at **www.dhrm.virginia.gov** and click on the EmployeeDirect link. It's quick, easy, and gives you immediate confirmation that your request has been received.

- **Paper:** Complete and return the attached State Health Benefits Enrollment Form for Employees to your Benefits Administrator. Be sure to allow time for it to be received within given deadlines.

State Health Benefits Program Enrollment Form For Employees

Review each section and carefully PRINT your enrollment information.

Section 1: Personal Information

Name _____ Identification Number _____
Last Name First Name M.I. ID or Social Security Number

Date of Birth _____ Gender: ☐ Male ☐ Female
Month/Day/Year

Important! *If your address has changed, be sure to verify the correct format at* **http://zip4.usps.com/zip4/welcome.jsp.**

Street Address _____ P.O. Box _____

City _____ State _____ Zip + 4 _____

Work E-mail: _____ Personal E-mail: _____

Work Phone: (_____) _____ Home Phone: (_____) _____

Section 2: Reason For This Enrollment or Election Change Request

Check all that apply and enter the appropriate date. The numbers in parenthesis are for agency use.

☐ **Newly Eligible Employee:** _____ (01)
Month/Day/Year

☐ **Open Enrollment:** (56)

☐ **HIPAA Special Enrollment Event:** _____ (70)
Month/Day/Year

QUALIFYING MID-YEAR EVENT from the list of events below: _____
Month/Day/Year

☐ Add to existing family membership (19)
☐ Birth or adoption (15)
☐ Change from full-time to part-time employee (77)
☐ Change from part-time to full-time employee (78)
☐ Child ceases to be eligible (38)
☐ Day care cost or coverage change (61)
☐ Death of child (17)
☐ Death of spouse (08)
☐ Divorce (10)
☐ Eligible for employer's plan (spouse or child) (28)
☐ Gained eligibility for Medicare or Medicaid (66)
☐ Judgment, decree, or order to add child (71)
☐ Judgment, decree, or order to remove a child (67)
☐ Lost employer eligibility (spouse or child) (13)
☐ Lost another government's-sponsored plan (76)
☐ Lost Medicare or Medicaid (09)
☐ Marriage (07)
☐ Moved into or out of a health plan's service area (05)
☐ Open enrollment or change allowed by other employer (62)
☐ Permanent custody of a child (72)
☐ Unpaid leave began for spouse (64)
☐ Unpaid leave began for employee (49)
☐ Unpaid leave ended for employee (50)
☐ Unpaid leave ended for spouse (63)

Section 3: Flexible Enrollment Accounts Election

Check all that apply and enter the appropriate pay period amount. A worksheet is available on the DHRM Web Site at www.dhrm.virginia.gov or from your Benefits Administrator.

☐ Medical Reimbursement Account Pay Period Amount $_____
Whole dollars only – Minimum Amount is $10

☐ Dependent Care Account Pay Period Amount $_____
Whole dollars only – Minimum Amount is $10

☐ I do not wish to participate in flexible reimbursement accounts

☐ No change requested for my **current plan year election** for flexible reimbursement accounts

Section 4: Health Care Coverage Election

Check the one that applies. The letters in parenthesis are for agency use.

- ❑ High Deductible Health Plan [HDHP] (CHD)

- ❑ COVA Care Plan (CC0)
- ❑ COVA Care + Out-of-Network (CC1)
- ❑ COVA Care + Expanded Dental (CC2)
- ❑ COVA Care + Out-of-Network + Expanded Dental (CC3)
- ❑ COVA Care + Vision + Hearing + Expanded Dental (CC4)
- ❑ COVA Care + Out-of-Network + Vision + Hearing + Expanded Dental (CC5)

- ❑ Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. – HMO (KP)

- ❑ I do not wish to participate in health care coverage (W)

- ❑ No change to my current plan year election for health care coverage

Identify the eligible family members you wish to cover under your health care plan. If you need more space, list additional family members on a separate sheet and attach to this form. The number of family members listed determines your membership.

❑ I do not wish to cover any family members.

❑ I wish to cover the following eligible family members:

Relationship Codes: H=husband W=wife S=son D=daughter SS=stepson SD=stepdaughter OF=other female child OM=other male child

RELATIONSHIP CODE	LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE MM/DD/YYYY	SOCIAL SECURITY NUMBER
Spouse					
Children					

Section 5: Employee Certification and Authorization

I certify that I have reviewed and understand the attached pages 1-4 of the State Health Benefits Program Eligibility, Elections and Enrollment Information For Employees and that I agree to abide by all participation requirements. I also certify that I am eligible for the benefits for which I elect to participate and that the information I have provided on this form is complete and accurate to the best of my knowledge. The health plan and its business associates have the right to use protected health information in connection with the treatment, payment and operations of a selected plan as defined by HIPAA.

Print Your Name _____ ID or Social Security Number_____

Sign Here_____ Date _____

Section 6: Agency Verification and Approval

Date Received _____ Month/Day/Year Date Keyed _____ Month/Day/Year BES Effective Date_____ Month/Day/Year

Print Contact Name _____ Phone _____ Agency/Group Number _____/_____